Nevada State Health Division

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NVS5818AGC	A. BUILDING: _____ B. WING _____	C 03/14/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
AMEERY CARE	333 PRINCE GEORGE RD LAS VEGAS, NV 89183

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
Y 000	Initial Comments The findings and conclusions of any investigation by the Health Division shall not be construed as prohibiting any criminal or civil investigations, actions or other claims for relief that may be available to any party under applicable federal, state, or local laws. This Statement of Deficiencies was generated as a result of a complaint investigation conducted on your facility 2/24/12 through 3/14/12. This State Licensure survey was conducted by the authority of NRS 449.150, Powers of the Health Division. The facility is licensed for 10 Residential Facility for Group beds which provide care to persons with Alzheimer's disease, Category II residents. Complaint #NV00030715 was substantiated. The allegation the facility failed to ensure a resident was not restrained was substantitated. See Tag Y0557. The allegation the facility failed to take pressure sore precautions was substantiated. See TAG 0823. Other deficiencies identified during investigation. See TAGs 0590, 0673 and 0850.	Y 000		
Y 557 SS=D	449.262(3)(a) Restriction on Use of Restraints NAC 449.262 Provision of dental, optical and hearing care and social services; report of suspected abuse, neglect, isolation or exploitation; restrictions on use of restraints, confinement or sedatives. 3. The members of the staff of a residential facility shall not: (a) Use restraints on any resident.	Y 557		

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Y 557	Continued From page 1 This Regulation is not met as evidenced by: Based on interview on 2/9/12, the facility failed to ensure 1 of 10 residents was not restrained (Resident #1). Findings include: Employee #1 admitted to restraining Resident #1 to his wheelchair using a Velcro belt. Severity: 2 Scope: 1	Y 557		
Y 590 SS=G	449.268(1)(a) Resident Rights NAC 449.268 Rights of residents; procedure for filing grievance, complaint or report of incident; investigation and response. 1. The administrator of a residential facility shall ensure that: (a) The residents are not abused, neglected or exploited by a member of the staff of the facility, another resident of the facility or any person who is visiting the facility. This Regulation is not met as evidenced by: Based on interview and record review on 2/24/12, the facility failed to ensure 1 of 10 residents was not neglected (Resident #1 - not provided enough fluids).	Y 590		

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Y 590	Continued From page 2 Findings Include: Resident #1 was an 81 year old male admitted to the facility on 5/1/11 with a diagnosis of Alzheimer's disease. According to hospital records, Resident #1 was admitted on 12/13/11 with a diagnosis of Alzheimer's endstage, sacral decubitus unstagable, fecal impaction, cachexia (wasting syndrome) and failure to thrive. The resident had a pressure ulcer, which had eschar of 3 to 4 inches in diameter floating on a bed of abscess. The resident was severely dehydrated, with a sodium level of 164. Through aggressive IV treatment, the hospital was able to get the resident's kidneys to function again and get sodium levels returned to normal. The son of Resident #1 stated that he received a call from a nurse at the hospital the day after his father was admitted. She stated that his father had kidney failure to due lack of fluids. Hospice records document that Resident #1 was admitted on 12/22/11 with a diagnosis of end stage Alzheimer's dementia. He was unable to swallow and failed a swallow evaluation. He was extremely cachectic. Upon admission to a local hospital, Resident #1 was diagnosed as severely dehydrated, and his kidneys were failing due to lack of fluids. Severity: 3 Scope: 1	Y 590		
Y 673 SS=D	449.2708(2) Discharge of Resident NAC 449.2708 Discharge of resident; notice of discharge; issuance of notice to quit to resident	Y 673		

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Y 673	Continued From page 3 for improper or harmful behavior. 2. Except as otherwise provided in this section, before a resident may be discharged from a residential facility without his approval pursuant to this section, the facility must provide the resident, his representative and the person who pays the bill on behalf of the resident, if any, with written notice that the resident will be discharged. This Regulation is not met as evidenced by: Based on interview on 2/24/12, the facility failed to ensure 1 of 10 residents was discharged appropriately (Resident#1). Severity: 2 Scope: 1	Y 673		
Y 823 SS=G	449.2734(2)(a) Pressure or Stasis Ulcers NAC 449.2734 Residents having tracheostomy or open wound requiring treatment by a medical professional; residents having pressure or stasis ulcers. 2. If a person who has a pressure or stasis ulcer or who is at risk of developing a pressure or stasis ulcer is admitted to a residential facility or permitted to remain as a resident of a residential facility: (a) The condition must have been diagnosed by a physician.	Y 823		

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Y 823	Continued From page 4	Y 823		

This Regulation is not met as evidenced by:
Based on interview and record review on 2/24/12, the facility failed to ensure pressure ulcer precautions were taken for 1 of 10 residents (Resident#1).

Findings Include:
Resident #1 was an 81 year old male admitted to the facility on 5/1/11 with a diagnosis of Alzheimer's disease. The resident's son stated that his father stopped walking and became wheelchair bound in mid-November 2011.

Employee #2, the owner of the facility, stated that she smelled a foul odor after passing Resident #1 in the facility in the first week of December, 2011. The owner stated she questioned a caregiver as to the source of the odor, and was told that the resident had a large pressure ulcer, and the Administrator of the facility was made aware of the problem. Approximately a week later, the Administrator informed Employee #2 that the resident should be transferred to another group home in order to receive care for the pressure ulcer. The resident was transferred to another group home at 5:00 PM on 12/13/11. Upon arrival to the group home on 12/13/11, the resident had a high fever and was immediately transferred to a local hospital.

Hospital records documented that Resident #1 was admitted on 12/13/11 with a diagnosis of Alzheimer's endstage, sacral decubitus unstagable, fecal impaction, cachexia (wasting syndrome) and failure to thrive. The resident had

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Y 823	Continued From page 5 a pressure ulcer with eschar of 3 to 4 inches in diameter floating on a bed of abscess, which had been draining purulent discharge. According to hospice records, the son of Resident #1 admitted his father to hospice on 12/22/11 rather than having a PEG tube inserted and surgical management of the wound. Resident #1 developed a pressure ulcer while in the facility, and the faility failed to ensure the resident recieved proper medical attention. Severity: 3 Scope: 1	Y 823		
Y 850 SS=D	449.274(1)(a) Medical Care of Resident NAC 449.274 Medical care of resident after illness, injury or accident; periodic physical examination of resident; rejection of medical care by resident; written records. 1. If a resident of a residential facility becomes ill or if injured, the resident's physician and a member of the resident's family must be notified at the onset of the illness or at the time of the injury. The facility shall: (a) Make all necessary arrangements to secure the services of a licensed physician to treat the resident if the resident's physician is not available.	Y 850		

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Y 850	Continued From page 6 This Regulation is not met as evidenced by: Based on interview on 2/24/12, the facility failed to ensure 1 of 10 residents family members and physician was notified following an injury (Resident #1). Findings Include: Resident #1 developed a pressure ulcer, and the son and resident's physician were not notified at the onset of the injury. Severity: 2 Scope: 1	Y 850		